DPHHS-HCS/CC-077
(Revision 12-11)

OFFICE USE
CAPS# _____
PS# _____

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

STATE OF MONTANA

- RELEASE OF INFORMATION -
Legally Certified Providers (LCP)
Criminal, Protective Services, and Motor Vehicle Background Checks

PERSONAL INFORMATION

Section A – Current Name and Residence

Ethnic Affinity: Hispanic or Latino ☐Yes ☐No Phone # _____

Legal Name: _____
(First) (Middle) (Maiden) (Last)

Aliases/Other Names Used: _____

Residential Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Sex: [ ] Male [ ] Female Date of Birth: _____ Social Security #_____

Marital Status: _____ Tribal Affiliation: _____ Race:_____

Section B – Past Residences

Have you ever …

1. …lived in another state? ☐ Yes ☐ No
2. …lived on or do you now live in an area designated as an Indian reservation? ☐ Yes ☐ No

If you answered yes to the any of the above questions:

- Please declare where you have lived in the table below.
- Out of state background checks or tribal background checks, will be required. There is a cost associated with these checks.

City	County	Reservation	State	Dates of Residency (From – To)

Section C – Prior Caregiver Approvals

Have you been… …certified/ registered / licensed to care for children before? ☐ Yes ☐ No
…approved, in any capacity, to provide care in a child care facility? ☐ Yes ☐ No

IF YES: Please give the Director / Facility Name and the Dates at the facility.

_____
(Director / Facility Name) (Dates)

Workers Initials _____ Date _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

LCP PROVIDER HOUSEHOLD INFORMATION

Section D – LCP Provider Household Member Status

The legally Certified Provider /In-Home Provider that I live with is: Provider #: _____

Legally Certified Providers Name: _____

Mailing Address :_____ _____

I am: the legally certified provider [LCP] & care will be provided

☐ in my home ☐ in the child's home ***or***

I am: ☐ the spouse of the LCP applicant ☐ a member of the LCP's household

Section E – Authorization Statement and Signature

As part of the initial and subsequent annual application process, I, _____ (applicant name) do hereby authorize any law enforcement and/or protective services agency to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services.

I, am aware that _____ (provider or its authorized representative), has requested confidential information from the Montana Department of Public Health and Human Services, in accordance with 41-3-205(3)(o), MCA as part of a review of my personal background in connection with said entity.

I am aware that Child and Family Services Division and, Department of Justice records may contain information that could adversely affect my Legally Certified Provider approval. These records will relate to criminal history records, as well as any report(s) of child abuse or neglect in Montana that indicates a risk to children. Records that indicate a risk to children are those that show a substantiation of child abuse/neglect on the person; and/or a history that shows that a child in the care of the person was adjudicated by a court as a youth in need of care, and/or a history that shows that the person has had their caregiver rights to a child terminated. As a household member, I understand that I am also subject to the above requirements.

I am also aware that although the entities or individuals requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidential nature, DPHHS has no ability or authority to ensure that confidentiality is maintained after this information is released by DPHHS.

In full acknowledgement of the above information and notice, I authorize CFSD to provide the requested confidential information to the provider or its authorized representative identified above, and **I hereby also release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.**

NOTE: Any deletions or oversights may result in the denial of your application.

Signed: _____ Date: _____

(*To be signed in front of a notary*)

TO BE COMPLETED BY A NOTARY PUBLIC:

Taken, sworn, and subscribed before me this _____ day of _____ A.D. _____

_____

PRINT Notary Public for the State of Montana

_____

Signature Notary Public for the State of Montana

Residing at _____

My Commission Expires _____

(*month/day/4 digit year*)

Workers Initials _____ Date _____